U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MICHAEL NOMURA, JR. and DEPARTMENT OF THE NAVY, SEA SYSTEMS COMMAND, Vallejo, CA

Docket No. 01-1761; Oral Argument Held July 18, 2002; Issued September 6, 2002

Appearances: *Steven E. Brown, Esq.*, for appellant; *Catherine P. Carter, Esq.*, for the Director, Office of Workers' Compensation Programs.

DECISION and ORDER

Before ALEC J. KOROMILAS, WILLIE T.C. THOMAS, MICHAEL E. GROOM

The issue is whether appellant has met his burden of proof to establish that his medical conditions are causally related to factors of his federal employment.

On or about November 20, 1998 appellant, then a 58-year-old shipwright, filed an occupational disease claim (Form CA-2) alleging that his left lung condition was caused or aggravated by factors of his employment. In pertinent part, he alleged that his lung condition was due to exposure to asbestos fibers, fiberglass, epoxies and other adhesives, paint, welding and fuel fumes, rubber and linoleum tiles, wood and wood filler, and having worked the graveyard shift. Appellant underwent a left lower lobe lobectomy in September 1998.

By letter dated January 5, 1999, the Office of Workers' Compensation Programs notified appellant of the factual and medical evidence necessary to establish his claim.

In response, appellant submitted a narrative statement of January 14, 1999 in which he described his job duties and work at the Long Beach Naval Shipyard, history of injury, symptoms and treatment. He noted that an exact medical condition had not yet been identified in his left lung. In a Form CA-20 dated November 24, 1998, Dr. Ronald S. Paul, a Board-certified thoracic surgeon at Kaiser Permanente Medical Center, diagnosed appellant with pleural effusion, unspecified; hemothorax; diabetes mellitus, without complications; placement of chest tube; and left lower lung lobectomy for bronchiectasis. Dr. Paul stated that it was "pending" as to whether any of the diagnosed conditions were related to any work injury. In a January 21, 1999 medical report, Dr. Chu-Shin Chiu, a Board-certified thoracic surgeon and internist at Kaiser Permanente Medical Center, advised that appellant was seen in July 1998 because of persistent hemoptysis for two and one half months. The bronchoscopy was negative. Because of the persistent hemoptysis, appellant was referred to thoracic surgery and underwent a left lower

lobectomy in September 1998. The pathology report of the left lower lobe showed severe bronchiectasis. Dr. Chiu noted appellant has diabetes mellitus, is a carpenter and had previous history of working at the Navy Shipyard with exposure to asbestos. Dr. Chiu opined that the cause of his bronchiectasis and hemoptysis was probably secondary to previous pneumonia. The thoracotomy was complicated by recurrent pleura effusion requiring chest tube insertion.

By decision dated February 16, 1999, the Office denied appellant's occupational disease claim on the grounds that the medical evidence was insufficient to support his claim.

By letter dated October 28, 1999, appellant, through his attorney of record, requested reconsideration and submitted a September 8, 1999 narrative medical report of Dr. Nachman Brautbar, a Board-certified internist specializing in nephrology. In his report, Dr. Brautbar noted appellant's occupational history of injury which included a detailed account of appellant's exposure to different substances during his various job duties. Appellant was noted to have a history of diabetes and high cholesterol. Physical examination findings were provided and appellant's medical records were reviewed. After providing a detailed discussion of appellant's medical records, Dr. Brautbar stated that the medical records were clear that appellant has been exposed throughout the years to various known irritants, and inflammation causing agents at the workplace to include asbestos dust, fiberglass dust and fumes and vapors. As a result of appellant's long term exposure to the irritants and inflammatory causing agents to the lungs, Dr. Brautbar stated that appellant developed, sometimes in 1991, what the chest x-ray described as chronic inflammatory changes of the left lung base, associated with abnormal pulmonary function test and symptomatology of shortness of breath. Dr. Brautbar noted a November 14, 1991 report of the Navy asbestos medical surveillance program which described infiltrate in round opacity of the left lung base. Dr. Brautbar further stated that, sometimes in 1998, appellant developed hemoptysis which required admission to the hospital and eventually required surgery in July 1998 due to persistent hemoptysis. As a result of the hemoptysis, appellant underwent left lower lobe lobectomy in September 1998 and the biopsy report showed left lower lobe bronchiectasis, which is a widening of the bronchus, due to repeated inflammatory and irritant changes. Dr. Brautbar noted that there are other conditions where bronchiectasis is genetically determined, but reported that there was no evidence that this is the case with appellant. He noted appellant's exposure to irritant materials (appellant did not smoke for the majority of his life and was otherwise not exposed to known irritant materials to the lungs, other than his industrial exposure to asbestos dust, fiberglass and chemical vapors and fumes). Dr. Brautbar noted that these types of exposures are known to be associated with chronic inflammation of the lungs with the development of bronchiectasis. Appellant's diagnosis was that of bronchiectasis, secondary to repetitive inhalational injury to the left lung as a result of asbestos, fiberglass and industrial vapors and fumes causing an inflammatory reaction as described in the chest x-ray in 1991, with ongoing symptomatology and leading to hemoptysis as a result of bronchiectasis described in the January 21, 1999 report by the treating physician. Dr. Brautbar opined that appellant has partially disability because of his work-related conditions and may only work light work.

The Office referred appellant, along with a statement of accepted facts, medical questions and medical reports of record, to Dr. Jerome Brown, a Board-certified internist specializing in pulmonary disease. After noting appellant's history of illness and review of the medical records

provided by the Office,[1] Dr. Brown set forth his examination findings and the results of a March 2, 2000 chest x-ray and pulmonary function test. A diagnosis of status post left lower lobectomy for bronchiectasis and moderate restrictive ventilatory impairment secondary to the first diagnosis was noted. Dr. Brown opined that he did not believe that appellant's condition was causally related to work factors described in the attached statement of accepted facts and job description. He advised that localized extensive bronchiectasis was not a condition which is considered related to asbestos, fiberglass or other sorts of inhalation exposures. In addition, there was no evidence on appellant's x-ray or physical examination of the usual findings associated with asbestos-related lung disease. Dr. Brown further advised that, by appellant's subjective indication, he is somewhat short of breath with activities such as climbing and occasionally while walking on level ground or carrying packages. He reported that appellant had been able to resume his prior occupation as of January 1999, apparently without any undue difficulty. Dr. Brown concluded that there were no physiologic abnormalities present which would preclude him from carrying out the job responsibilities as a carpenter. He further found that appellant was permanent and stationary and, under the American Medical Association, *Guides to the Evaluation Permanent Impairment,* fourth edition opined that, based upon the 60 percent of predicted vital capacity, appellant would be a Class II, mild impairment of the whole person. No specific recommendations for further medical evaluation were noted with the exception that, if appellant's asbestos exposure was documented and accepted, then periodic chest x-rays and pulmonary function testing would be reasonable.

The Office determined that there was a conflict in the medical opinion between Dr. Brautbar and the government physician, Dr. Brown, and referred appellant to Dr. Mudit Dabral, a Board-certified internist specializing in pulmonary critical care for an impartial medical examination. A copy of the statement of accepted facts and questions was sent along with the case record for Dr. Dabral to review.[2] In his report dated May 17, 2000, Dr. Dabral interviewed and examined appellant and reviewed appellant's records, including the evaluations of Drs. Brown and Brautbar, and advised that he would not go into details of appellant's previous exposure, medical history, *etc.*, as it was well outlined in those evaluations. After reviewing in detail the medical and factual evidence of record, in addition to interviewing and examining appellant, Dr. Dabral stated that it was established that appellant had left lower lobe bronchiectasis (localized bronchiectasis) leading to hemoptysis and requiring left lower lobectomy in September 1998. He reported that appellant had not had any recurrence of hemoptysis. Dr. Dabral further related that no obvious fibronodular densities were seen on chest x-ray. No pleural plaquing or pleural effusions were identified. No pleural thickening had been noted until recently. The only abnormal x-ray findings reported back in 1991 and 1993 were what appears to be bronchiectatic changes in the left lower lobe. Dr. Dabral opined that, based on the clinical research to date, there is no documented case of bronchiectasis arising from asbestos exposure. The toxic inhalations which cause bronchiectasis are usually generalized

[1] The Board notes that Dr. Brown did not review the medical records appellant brought with him. However, this is harmless error as Dr. Brown had an adequate history in light of the statement of accepted facts and medical records of file in which to formulate his opinion. Furthermore, the disposition of this case does not rest solely on the opinion of Dr. Brown.

[2] The Board notes that appellant's attorney had participated in the formulation of the final questions which were sent to Dr. Dabral.

bilateral diffuse, and have been seen with sulfadioxide, ammonia, and other chemical inhalations. Focal bronchiectasis is usually due to recurrent aspiration, previous bronchopneumonia, especially whooping cough as a child, or possible endobronchial obstructions. Based on the findings of appellant's objective testing to date and the fact that appellant has localized bronchiectasis which did not fit the pattern of bronchiectasis arising from asbestos exposure or toxic inhalations, Dr. Dabral opined that he did not feel appellant's condition was related to exposure described in the attached statement of accepted facts. Based on the pulmonary function tests, which were done after the left lower lobectomy, Dr. Dabral opined that appellant had moderately restrictive ventilatory dysfunction and was limited in doing strenuous exercise, especially on a consistent basis for six to eight hours. Residual pain in the surgical site also caused some activity limitation. Dr. Dabral recommended that appellant be seen by his primary care provider for other medical conditions, such as cardiovascular and sleep apnea syndrome, which may need to be investigated. However, he opined that none of those other conditions were related to appellant's employment. Dr. Dabral further recommended that appellant should undergo a high resolution computerized tomography scan to see whether there were any fine pleural pulmonary findings. Dr. Dabral, however, did not state what a finding of fine pleural pulmonary would mean in regard to appellant's workman's compensation case.

In a decision dated June 23, 2000, the Office found that the weight of the medical evidence of record, represented by the opinion of Dr. Dabral, the independent medical examiner, established that appellant's diagnosed condition of bronchiectasis was not causally related to the identified employment factors.

The Board finds that appellant has not established that his pulmonary conditions are causally related to factors of his federal employment.

In finding appellant's lung condition to be unrelated to his industrial exposure, the Office relied on the opinion of Dr. Dabral, as the impartial medical examiner. In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical examiner for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[3]

The Board finds that Dr. Dabral's opinion is complete and well rationalized in establishing that appellant's current condition and related disability are not causally related to the identified employment factors. Dr. Dabral reviewed appellant's medical history at length, considered all the relevant diagnostic tests, performed a physical examination and concluded that appellant's condition of localized bronchiectasis and ventilatory impairment was unrelated to appellant's work factors as the clinical research showed no documented case of [localized] bronchiectasis arising from asbestos exposure. Dr. Dabral concluded that the toxic inhalations which cause bronchiectasis was usually generalized bilateral diffuse and that focal bronchiectasis was usually due to recurrent aspiration, previous bronchopneumonia, especially whooping cough as a child, or possible endobronchial obstructions. As the independent medical examiner, Dr. Dabral's opinion constitutes the weight of the medical evidence. Contrary to appellant's

[3] *Kathryn Haggerty*, 45 ECAB 383, 389 (1994); *Jane B. Roanhaus*, 42 ECAB 288 (1990).

attorney's assertions on appeal, Dr. Dabral sufficiently answered the specific questions pertaining to causal relationship.

The June 23, 2000 decision of the Office of Workers' Compensation Program is hereby affirmed.

Dated, Washington, DC
September 6, 2002

Alec J. Koromilas
Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member